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Devoted to the interests and advancement of those engaged in school health activities and the service rendered by them

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Editor
CHARLES H. KEENE, M.D.
University of Buffalo, Buffalo, N. Y.

Assistant Editor
GERTRUDE E. CROMWELL, R.N.
Denver, Colorado

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In the City of Baqdad lived Hakeem, the Wise One, and many people went to him for counsel, which he gave freely to all, asking nothing in return.

There came to him a young man, who had spent much but got little, and said: "Tell me, Wise One, what shall I do to receive the most for that which I spend?"

Hakeem answered: "A thing that is bought or sold has no value unless it contains that which cannot be bought or sold. Look for the Priceless Ingredient."

"But what is this Priceless Ingredient?" asked the young man.

Spoke then the Wise One: "My son, the Priceless Ingredient of every product in the marketplace is the Honor and Integrity of him who makes it. Consider his name before you buy."

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MANUFACTURING CHEMISTS TO THE MEDICAL PROFESSION SINCE 1858

THE JOURNAL OF SCHOOL HEALTH

Devoted to the interests and advancement of school health service and instruction. Your participation by membership is solicited.

Vol. XX FEBRUARY, 1950 No. 2

OPHTHALMOLOGICAL PROGRAM IN THE PHILADELPHIA SCHOOLS*

(September 1945 to June 1949)

RALPH C. LANCIANO, M.D.

Supervisor in Charge of Eye Program

The Pennsylvania School Health Act (1945) specifically states that all children of school age in the Commonwealth who are in school or should be in school, must have complete Medical and Dental examinations once every two years while they are members of the first, third, fifth, seventh, ninth, and eleventh grades.

The school pupil may have medical or dental examinations made by his private doctor or dentist, at his own expense, submitting the record of examination to the local school health authorities on forms prescribed by the State.

The need for the organization of a well-balanced Eye Program to serve as an auxiliary unit to the complete physical examination conducted by the Division of Medical Services, was long recognized by the school authorities. As a result of this, the Eye Program now in effect began its development in March, 1946. Its organization was predicated upon the following objectives:

1. The establishment of an effective in-service training program for school medical inspectors and school nurses, so that they may become familiar with their duties and responsibilities in the proper conduct of ocular examinations.
2. The placing with the school medical inspector the sole responsibility of examination, recording, and referring for further study any pupil whose visual and ocular defects or complaints necessitates such care.
3. The complete ocular examination of pupils referred to the various Board of Education Clinics maintained by the Division of Medical Services are being conducted by qualified well-trained ophthalmologists in accordance with regulations set forth by the consulting ophthalmologist, Dr. Edmund B. Spaeth.

* Presented before the American School Health Association, New York, N. Y., October 24, 1949.

4. Emphasis being placed on correcting the number of correctible ocular defects found to the fullest extent of all the resources available.

The Eye Program of the Medical Division of the Philadelphia Board of Public Education as now in effect was organized with the following objectives in mind:

1. To discover the number of ocular defects present in pupils of the Public School System undergoing complete physical examinations as required by the School Health Act PL 1222, of the Commonwealth. 398,998 pupils have been given complete physical examination for the school years September, 1945 to June, 1949.
2. To report eye defects found to the parents with the request that the family physician be consulted and corrective measures instituted wherein indicated.
3. To correct eye defects of pupils, whose family income does not permit private care, through the Ophthalmological Section of the Board of Public Education.
4. To examine, refer, and admit to the Low Vision or Sight-Saving Classes, pupils whose ocular defects are of such severity that they interfere with education in regular classes.
5. To admit to Institutions for the Blind, pupils of compulsory school age, whose visual defects are so advanced that admission or continuation in Low Vision Class is no longer of value to the pupil's education.
6. To obtain Orthoptic and Surgical care for extraocular muscle abnormalities.
7. To make ocular examinations of all pupils showing evidence of systemic disorders that present ocular manifestation.
8. To provide ocular welfare for indigent school pupils.
9. To examine pupils with reading disabilities, referred by the Division of Special Education.
10. To provide ocular and visual welfare for the physically handicapped, i.e.; Deaf, Deaf Mutes; Paralytic and Orthopedic cases; Sight-Saving and Low Vision Groups.

In accordance with the requisites of the Pennsylvania School Health Act PL 1222, the ocular examination of all school pupils is a part of the general physical examination conducted by the school medical inspectors.

The *School Medical Inspector* determines the visual acuity by the use of the Snellen chart at 20 or 15 feet, recording the visual acuity for each eye separately. Near Vision, using the "near

vision" chart as formulated by the Division of Medical Services is determined for each eye at 14 inches distance. External examination is made of the lids, conjunctiva, cornea, and pupils, and any abnormalities present and recorded. Strabismus, if present, is noted as to position of deviation and measurement of deviation by the Hirschberg method.

The pupil's ocular complaints, as well as the school nurse's and the teacher's impressions of the behavior of the pupil are evaluated. Pupils found with ocular abnormalities needing medical attention are reported to their parents or guardians with the request that the family physician be consulted and correction instituted. If the economic status of these families do not permit private medical care, the parents or guardians give consent to the school system to assume the responsibility for treatment of these pupils. On receipt of parental consent, pupils requiring eye care are listed with the School Nurse Service, and the Nurse Coordinator makes appointments for eye examinations at a designated school eye clinic.

Examinations in the Eye Clinics:

The Medical Division of the Philadelphia Board of Public Education maintains four fully equipped eye clinics, one diagnostic center, and 11 cooperating Philadelphia hospital units. These eye clinics have been geographically located in the Philadelphia area so as to assure easy accessibility and minimum travel on the part of the pupil, parent, and school nurse.

Pupils are brought daily by the school nurse to the designated eye clinic of the district. The pupil's school medical record, which includes the ocular abnormalities noted by the school medical inspector and his recommendations, are read and evaluated by the attending ophthalmologist. Visual acuity under the effect of cycloplegia is noted and recorded for each eye, compared with the visual acuity without cycloplegia, as reported by the school medical inspector. Complete external examination, determination of muscle imbalance for distance and nearby, the use of the Cover Test and Prism Test, ophthalmoscopic examination, cycloplegic refraction, Trial Frame examination follow, and the findings are recorded. Cases requiring post-cycloplegic examination are returned at a later date. The need for post-cycloplegic examination is left to the discretion of the ophthalmologist. Glasses are issued on the basis of the degree of refractive error, pupil's ocular complaints, and study of the muscle balance. A copy of the findings and recommendations of the ophthalmologist are forwarded to the school,

and become a part of the school health record. Parents are notified of the recommendations and findings. Cases that reveal evidence of active or quiescent anterior segment or posterior segment pathology are referred to the central diagnostic clinic for further study. These studies include Slit Lamp Examinations, Perimetric and Field Studies, and Ocular Muscle Studies. Cases requiring hospital care or surgical correction are listed with the supervisor's office, and arrangements are made through this office for their admission to one of the cooperating hospital units. Payment for all surgical and medical care is effected through the Department of Public Assistance.

Low Vision Classes — W. & E. Martin School and T. M. Peirce School

Pupils who in the course of routine eye examination reveal a bilateral vision of 20/70 to 20/200 without regard to simultaneous binocular vision or any degree of binocularity allowing correction by eye-glasses and regardless of any study of the fields of vision, are considered candidates for the Low Vision or Sight-Saving Classes.

These pupils are referred for special eye examinations in the eye clinic of the Martin School. These cases obtain complete examinations, including Slit Lamp and Field Studies. On the basis of his findings, the examining ophthalmologist may recommend the admission of these pupils to Sight-Saving or Low Vision Class. The request for the transferral of these pupils from regular class to Martin School follows. The Department of Special Education is then notified, and a psychological intelligence rating examination follows.

Pupils in Sight-Saving Classes receive semi-annual ocular examinations by the attending ophthalmologist, and degrees of progression or stability of their ocular defects are observed and recorded. The requirements for admission to Sight-Saving or Low Vision Classes are as follows:

1. Bilateral vision of 20/70 to 20/200 without regard to simultaneous binocular vision, or any degree of binocularity, allowing correction by eye-glasses (corrected vision), and regardless of any state of the fields of vision. Pupils with vision less than this, are properly cases for an Institution for the Blind.
2. Visual acuity of any degree with the fields of vision contracted to within the 10-degree isopter. Visual acuity of less than 20/50 with such peripheral fields of vision may, also,

be cases for an Institution for the Blind when due to progressive congenital anomalies and degenerations.

3. Field defects, regardless of type, of such a nature as to interfere with the pupil's ability to attend regular classes.

TABLE NO. 1

RESULTS OF EXAMINATIONS AND CORRECTIONS OBTAINED BY BOARD OPHTHALMOLOGISTS

	Examined by Board Ophthalmologists	Defective Vision Corrected	Low Refractive Error Not Warranting Correction	Irremedial Defects
1945-46	2023	1657	346	20
1946-47	3322	2064	1216	42
1947-48	5577	3883	1642	52
1948-49	5675	4305	1331	39
Grand Total	16597*(34.4%)	11909 71.7%	4535 27.3%	153 .92%

*(48231 TRSMI)

TABLE NO. 2

DISPOSITION OF VISUAL AND OCULAR DEFECTS REPORTED BY SCHOOL MEDICAL INSPECTOR

	Complete Physical Examinations	Defective Vision Reported	Examinations By: Board Ophthalmologists	Private Agencies	Philadelphia Hospitals	Total Examined
1945-46	98728	12486	2023	5001	210	7234
1946-47	100359	12540	3322	5404	229	8955
1947-48	98847	12217	5577	5563	186	11326
1948-49	101064	10988	5675	5359	269	11303
Grand Total	398998	48231	16597	21327	894	38818

* * * * *

WANTED — A SUMMER CAMP NURSE

Well established girls' camp in Northern Wisconsin. Public Health Nurse used to dealing with children or a school health nurse for a period of nine weeks—June 23rd to August 30th. Write: Mrs. Jack C. Griffin, 9446 N. Hamlin Ave., Evanston, Illinois.

CONTRIBUTIONS OF THE SCHOOL NURSE IN A SCHOOL DENTAL PROGRAM

EMILY S. BROWN, R.N., B.S.

Past President, New Jersey State School Nurses' Association, Present Representative to American School Health Association.

1. The school nurse, the pivot about which the dental program is organized and functions.
2. Observed opportunities for character and personality changes as presented by the Dental Health Program.

The school nurse, the pivot about which the dental program is organized and functions:

A realistic approach to the School Dental Health Program faces us with the fact that no matter how many people in and outside the school actually participate in the program, the school nurse is primarily the one everyone looks to, in order to start things moving and to keep them moving.

Few schools have a full-time dentist, which means that the school dentist relies heavily upon the nurse to interpret his findings and help people to secure the necessary dental care.

While the nurse is the chief responsible agent to see that the dental program is carried on, she cannot do this however, without the cooperation of the administrator and the entire teaching staff. A successful dental health program is the result of good team work between all concerned, with the nurse at the helm sending out the necessary notices to parents, fully informing teachers and administrators of the dental defects noted by the dentist and interpreting his findings in terms of what progress they may or may not reveal. A showing by percentages of the present situation and comparing it with the past records, is a helpful means of interesting pupils and teachers to work for further goals. The senior and junior high school groups particularly like a race and a flare of competition.

A system of close checking and reporting back and forth between nurse and homeroom teacher is highly desirable in keeping both up to date on the ever changing dental picture in the school.

The nurse is usually the one to initiate special dental programs, exhibits, etc., requiring special equipment, speakers, etc., although she may motivate social studies, science and health

Presented October 25, 1949, Dental Health Session, Annual Meeting of the American School Health Association, Hotel New Yorker.

groups to undertake such projects as a part of their assignments. Being the indirect initiator for pupils to assume dental studies on their own, is perhaps far better health teaching on the part of the nurse and is apt to secure action for better teeth in great numbers of those pupils who did something on the project.

The nurse must also see herself in the role of a sound informer and consultant for teachers needing up-to-date scientific material to draw upon in teaching, as well as for parents needing practical guidance. For this reason, she must keep herself abreast of the best practices and be reasonably informed on current trends.

The enormous task of obtaining dental care for every child must, of course, be approached as the responsibility of the community as well as the school and so, in this connection, the nurse will do well to encourage the formation of a Dental Health Council in the community if one does not already exist.

The Council might be a part of a general community health council. It should include representation from the schools, parents, interested lay people and dentists, who together will develop workable facilities and policies for carrying out an adequate community dental health program. The school should tie itself very strongly to such a council and make it's voice heard well, for the school knows in most every instance, the dental situation at first hand, and this is only possible because of the careful work of the school nurse.

Observed Opportunities for Character and Personality Changes as Presented by the Dental Health Program:

In discussing this point, it is not presented with the view that it is a new discovery. Very likely many of you have had similar experiences, but it is presented for emphasis, as a suggestion for enriching routine procedures, as well as helping to build permanent attitudes, which will lead to improved patterns of behavior.

Generally speaking, as school nurses, we do not think of our counseling and corrective work as offering possibilities for the improvement of character and personality. We are mainly working for tangible results in improving the physical welfare of the school child. It seems like a very concrete area of endeavor, as indeed it is.

We usually expect that our efforts will cause the individual either to do something we think is good for him or to stop doing what is injurious. Various methods, subtle and otherwise, are employed in the classroom and in personal contacts to achieve the desired goal.

Changes in behavior are expected, since this is the very aim of health education, but in our routine work of attempting to reach these more favorable ends, we do not usually take into consideration the fact that any change in behavior, brought about in a person has a deeper implication than what is discernible to us in his outward deportment and may come to alter profoundly the individual's entire attitude toward life and his environment. Something deep within him has changed, which is mirrored in his changed behavior.

This fact of course is not new to you, but can easily be lost sight of in the maelstrom of a heavy routine which more and more these days seems to be the slave of statistics and more and more records. It is highly important however, to bear in mind, for within it lies a most precious tool for personal development.

I have found that the school dental health program provides a richer opportunity for motivating character and personality changes in students than any other phase of our health work.

Dental health in the majority of cases, is something that has to be acquired by subjecting ourselves in varying degrees to discomfort, even pain sometimes, self-discipline and emotional control. It is unique in this—children for example do not fear to go to their family physician in the same way they fear going to a dentist.

For the most part, dental health is something no one can give you, unless you cooperate to obtain it. With a few exceptions, nature has given no effortless handouts in dental health. A certain few do seem free from dental caries, but in the present stage of scientific knowledge regarding dental decay, regular visits to a dentist in combination with certain sound health habits, seem to be necessary for the vast majority of people.

The picture may change. Science may someday triumph over the cause of dental decay, but until that day arrives, we have to obtain dental health the hard way.

Great numbers of little children and young people, as well as the oldsters, resist the dentist. It is sort of a natural response and surely provides one of the greatest obstacles in achieving successful dental health programs.

It is fear then, with which we so often have to deal in our school dental work. If we can achieve some measure of success over it, it is my contention that we are really giving the child something to stay by him for life.

In spite of the comforts and conveniences of these modern

days, as a people we are full of fears. People fear cancer, they fear arthritis, they fear polio, they fear the power of atomic energy, they fear war. Fear is cumulative, like the proverbial snowball. One fear leads to another and may easily develop a life pattern of fears and inhibitions. Can we help our children to learn to resist and overcome fear?

It has been my observation over many years, that students who have overcome their fear of going to the dentist and who have followed through to the necessary treatment, develop a stamina and confidence they did not appear to have before and have often become different personalities.

Many times, of course, the characteristics they have exhibited did not appear to be those of fear, but could later be viewed as among those protective, defensive attitudes which have their roots in fear.

It is because of the possibility of this extra dividend, as it were, occurring, that we should from the start, in our dental health education, be on the alert to foster it—either with groups or more especially with individuals. It is not so much direct action to be taught, as it is an attitude to be developed. The idea is that dental discomfort and the facing of an unpleasant duty is a part of life to conquer. It may be likened to a great wave that comes in the swell that we must breast. Thus dental health may become not an isolated task but a part of the whole life response.

I am going to cite 3 or 4 cases that I have had the privilege of working with, which illustrate the point I have tried to bring out:

1. Barbara—aged 8, 3rd grade: Teeth extremely poor, an only child, peevish, petulant, always making excuses. Refused all attempts at dental care. Mother alternately indulged and whipped her, for what she told the nurse was B's impossible disposition. There were many conferences with Barbara.

   Dental care was not instituted until her 9th year, then had to be taken in very slow steps. The dentist was an unusually patient person who liked dealing with children.

   Today, Barbara is 11 years old. Her teeth are in excellent condition except for a slight malocclusion, which resulted from the early neglect. The 6 year old molars were saved. Best of all is the total change that has come over her. She is extremely proud of having won out with herself—that is about the way she puts it. She even says

that she is not afraid of anything now.

Her teacher reports "an even temper, good class spirit and very cooperative, even if she still does like attention —but who doesn't!"

2. James W.—age 15, 8th grade, junior high school: Extreme dental case. Overgrown for age and somewhat retarded. Very anti-social. Attended dental clinic once and refused any further care. Parent supported boy against the school.

   Making application to the local Vocational School before graduation from junior high school made dental work imperative.

   James was finally won over to go to his own dentist, which he did to the complete satisfaction of the school authorities.

   The change in James followed the completion of his dental work, which took place during the summer following his junior high school graduation and some of his 10th year. It was nothing short of specacular. He learned to smile at people and forgot all of his defensive, belligerent tricks. He became a good Vocational student and continued regularly with the dentist.

3. Florence—7th grade, junior high school: All teeth extremely bad, probably impossible to be saved.

   Florence had refused all dental care during her elementary classes. When she entered junior high school, she was highly nervous, posture poor, nails bitten, refused to participate in any auditorium programs. Dental care was not instituted until just before she entered the 9th grade. A partial upper plate was necessary, but most of the lower teeth saved.

   Graduated last June from the 9th grade. Florence was not the same girl. A veritable metamorphosis had taken place in her. She has become a chatty, happy student, who participated normally in everything and had complete confidence in herself. She admitted to me as the school nurse, that "her teeth made a different person of her." Incidentally, she conquered the nail biting habit also.

4. William G.—Age 15 years, 10th grade: Entered Vocational School with many promises that dental care would be started. Many conferences were necessary and considerable approach made along the lines mentioned in this

paper. Finally, William got up courage to go to the dentist, in his last year and completed all the necessary work. My reward came when he reported to the nurse's room just before graduation to thank me for "keeping at me," as he put it, for he said, "I would never have done it unless you had treated me the way you did and I will always be grateful. It just makes me feel different somehow, about everything."

I could cite many more, such as a high school boy who, after conquering the dentist came to me one day and asked me bluntly: "Say, if I could lick that dentist, do you think I can stop smoking?"

But enough has been said to put across my point. More is involved in the Dental Health Program than merely getting children to have clean, healthy mouths, important as that is—and I would not minimize it.

However, you can see that the little child who has been successfully persuaded to make repeated trips to a dentist and has conquered his fear, has unconsciously achieved a victory in character formation and if properly guided by his teachers and parents, may well be led to other conquests calling for stability and endurance.

For the older student, such an accomplishment presents a thrilling sense of achievement and self-confidence, which he should be encouraged to capitalize on.

In all of this, the school nurse is the one person who can direct and promote this emphasis, because it is her direct responsibility to see that the dental program moves forward and also, because students and teachers alike come to her in confidence for help and guidance.

So it becomes her thrilling opportunity to give a dynamic touch to dental health education and to make a prosaic routine phase of corrective work, a spear head for new response patterns —new learnings—and it is not too much to say, new strengths of character.

Such contributions will well justify all her efforts.

* * * * *

PHYSICAL FITNESS TESTS OF TOP AMERICAN ATHLETES
(Preliminary Report)

By THOMAS K. CURETON, JR.
University of Illinois

Some seventy top American athletes were tested during the summer of 1948 in accordance with the plans of the sub-committee of the U. S. Olmpic Medical and Nursing Committee under Dr. Leroy Mercer. The general advisory chairman of this work was Dr. A. C. Ivy, of the University of Illinois. Most of the work was carried out in Urbana, at the Physical Fitness Research Laboratory, directed by Professor Cureton. A number of notable athletes were tested, including 22 men swimmers and divers who represented the U. S. at London last summer; also, some 25 track and field stars, several gymnasts, and a few wrestlers and skaters.

The data represented by over a hundred tests of physique, organic condition and motor characteristics are valuable for individual case studies and group comparisons but will also make a basis for following certain individuals over a period of years in subsequent tests to compare the differences between "in training" and "out of training" and, over a longer period of time, the degree to which athletes maintain their fitness compared with other types of individuals. At the Illinois laboratory several hundred team athletes and other individuals from all walks of life have been tested.

A preliminary report on this work is now being prepared partly as a basis for studying the methods and results already obtained. It is expected that the testing will go on continuously related to testing a wider range of athletes and normals and in follow-up comparisons. The data already available are summed up in units entitled:

1. Measurements of body type
2. Anthropometric proportions
3. Heart size
4. Flexibility
5. Jump reaction time
6. Breath holding
7. Cardiovascular tests
8. Sitting pulse wave and heart minute volume
9. Electrocardiogram
10. Maximal circulatory-respiratory tests
11. Treadmill running efficiency
12. Maximal athletic performance strength, agility, general dynamic tests

From a very broad and preliminary point of view the results may be summarized as showing:

1. Several athletes of the *power* type are shown to be extremely mesomorphic and cluster at the peak of the body type triangle, such as Bill Mathis, Wally Ris, Joe Verdeur. Very close to the top were Charles Fonville, Allen Stack, Bill Smith, and Bob Sohl. Every swimmer who had broken a world's record was very high in the mesomorphy component.

2. By scaling the proportions of the body and the limbs of some of the 1948 Olympic athletes and also the 1928 Olympic athletes from good photographs available definite trends are shown in that:

(a) Top ability jumpers, high hurdlers, and pole vaulters usually have relatively longer forelegs to thighs and greater total leg length to height than jumpers of lesser ability and these proportions are outstanding when compared with the averages of normal young men of the same age and college environment. Ganslen, Eddleman, Finley, Duff and Meadows are typical men with jumping proportions.

(b) Fonville has upper arms and total arm span of relatively greater length than any other athlete measured; his ratio of upper arm length to forearm length is the greatest measured and he is a heavy built, 220 pound athlete built in the power-jumping pattern, who can high jump 6 feet. These proportions for a combination of power and spring no doubt help to explain his record of 58 feet 3/16 inches in the shot put.

(c) Weight lifters and wrestlers usually have relatively short levers in length of limbs to length of trunk. They are stocky mesomorphs as a rule, sometimes with accumlated fat. In this class are Kachiroubas, Ryan and one skater, George Fisher, and several acrobats and the Olympic divers.

3. Swimmers are very usually angle or flat floaters and have unusual floating capacity, especially the breast strokers and the 400 and 1500 meter men. Even the beautifully muscled Joe Verdeur is an excellent floater as is also thin Jim McLane. Very unusual flexibility is also a leading characteristic of the top swimmers, in the chest vital capacity, in the arching of the trunk backwards and in ankle flexibility. The 1948 U. S. Olympic swimmers (20 men) averaged 16.3 points on the Schneider test, the highest group average ever reported; they also had the lowest pulse rates after 1, 2 and 5 minute stool jumping; and the Brachial pulse wave area was relatively enormous in the endurance swimmers compared

to the sprinters and agility athletes. Verdeur, Alan Ford, Bill Smith and Forbes Norris had very strong waves, suggestive of strong hearts which deliver a great deal of blood per minute.

4. The track sprinters, low hurdlers, shot putters, vaulters and jumpers tested relatively at the top in the vertical jump reaction time in response to light and sound signals. Bill Mathis, Herb McKenley, Bob Richards, Lloyd Duff and Charles Fonville were very fast relatively. Most of the swimmers were relatively slow.

5. Herb McKenley, Bob Rehberg and John Twomey were shown to have relatively large hearts for their surface area size. McKenley in track (400 m.) and Norris (1500 m.) in swimming had relatively the largest hearts, but the two Olympic divers, Bruce Harlan and Sammy Lee, also averaged relatively large. In general several 1948 athletic groups ranked almost exactly by averages in the heart volume/body weight ratio and in the Ungerleider-Clark heart transverse diameter tables as Herxheimer had ranked them in his European studies. Middle distance runners, McKenley, Guida (400, 88 m.) and swimmers, Wolf, Dudley, Hoogerhyde, Huesner (200 m., 400 m.) averaged the largest in the normal transverse diameter and in the ratio.

6. Breath holding capacity appears to be associated with oxygen debt capacity. The breath holding time of good athletes taken on the Flarimeter after a standardized stepping exercise is significantly greater than that obtained as an average on various groups of young men.

7. In the Harvard 5-ft. Step Test based on pulse counts after exercise the swimmers averaged 122 for the three 30 sec. pulse counts at 1, 2 and 3 mins. after the exercise. Twelve of the 19 Olympic swimmers tested went over the top of a previously prepared rating scale based on several hundred young men. The 200, 400 and 1500 m. men did better than the 100 m. men.

8. Certain athletes of top ability in swimming and track show relatively slow pulse rates, 14 track athletes averaged 49; 21 swimmers averaged 65; 81 controls averaged 68. Certain top flight athletes had enormous heights of the EKG R wave in mms.: Meadows, 33.5; Huesner, 33.0; Norris, 32.5; Gilbert, 32.4; Fonville, 30.0; Duff, 29.0; Stack, 27.0; Ford, 23.0. The highest in the fourth or fifth lead is quoted. Also, there were some enormous T-waves in the fourth and fifth leads: Fonville, 22.7; Ris, 16.8; Duff, 16.5; Gibe, 15.7; Hoogerhype, 15.0; Wolf, 15.0; Smith, 14.2; McKenna, 14.2; Lee, 14.0. It would be very interesting to see if these large deflections reduced after training is discontinued.

9. The endurance track athletes developed the greatest oxygen intake per minute but the swimmers were not tested on this event. Predictions of running time on the treadmill were possible with the following validity coefficients: total oxygen used, .83; pulse wave area/surface area of body, .70; oxygen intake/min./Kg., .60; oxygen debt/min./Kg., .70; basal metabolic rate, .54; .628 (Schneider Index + .479 St. Dias. B.P.) in standard scores correlated, .54; heart size by Ungerleider-Clark norms, 52; and breath holding on Flarimeter after 1 min. stool stepping at 30/min. rate, .40.

10. Power athletes (sprinters, jumpers, hurdlers, shot putters) have a great deal of strength by the strength/weight ratio. Ford, Gilbert, Gibe, Carter and Verdeur were highest among the swimmers. The divers were not tested. The weight residuals of 19 Olympic swimmers averaged + 18.78 lbs., of 14 superior track athletes, + 18.71 lbs., 173 Springfield College freshmen + 4.66 lbs., 110 medical freshmen + 4.854 lbs. The bone, muscle, fat proportions of the Olympic swimmers were 5.2, 2.6 and 2.0 standard score per cent *above* the means of normal young men; whereas, the same items were 9.1, 12.0 and 22.1 per cent *below* the means for normal young men. The swimmers are wonderfully developed with measures of strength, strength/weight, weight residuals, vital capacity, buoyancy and cardiovascular condition considerably above average values for young men. The track and weight athletes are faster and are highly specialized in their events. They are typically well-muscled men with the runners, jumpers, vaulters and hurdlers built in a lithe pattern with linear bones and very little fat over the muscles or within the muscles.

Reprinted from Journal of Physical Education, September-October, 1949. The complete report will soon be available.

* * * * *

"CITATION"

For the William A. Howe Honor Award

Clair Elsmere Turner—Tonight, the American School Health Association honors itself as well as this outstanding worker in the fields of public health, sanitation and health education.

Born at Harmony, Maine, he holds the degrees of B.A., Bates College, M.A., Harvard University, C.P.H. and Dr. P.H., Massachusetts Institute of Technology, Sc.D., Bates College, Ed.M., Boston University.

Married Naomi Elsie Cocke, and has two fine children.

He has served on the faculties of Bates College; University of California; Tufts College, Medical and Dental Schools for twelve years; and the Massachusetts Institute of Technology. At the latter he became Professor of Public Health and head of his department. Functioned as consultant in Health Education for the Boston Health Department, Illinois State Department of Health, Kansas State Board of Health; became Chief Health Education Officer, Division of Health and Sanitation, Office of Institute of Inter-American Affairs; member of Administrative Board, Harvard—Technology School of Public Health, where he set up the first organized training of Health Educators presented at any school of Public Health; Lecturer, University of Hawaii, University of the Philippines, China Central University; Sanitary Engineer, U. S. P. H. S. during World War I; director of Malden (Mass.) Studies in Health Education and Growth; Editor, Health Films, Eastman Teaching Films; member of the Executive Board of the Am. P. H. A.

He has borne "his blushing honors thick upon him"; Trustee of Bates College, Fellow American Association for Health, Physical Education and Recreation, American Public Health Association, American Academy of Arts and Sciences, American Academy of Physical Education, American School Health Association (President 1942-43), Associate Fellow American Medical Association, American Association Advancement of Science, Member American Museum of Natural History, National Education Association, Massachusetts Civic League, Sigma Xi, Phi Beta Kappa, Delta Sigma Rho, Delta Omega, Phi Delta Kappa, Chairman Health Section, World Federation of Educational Associations, member of numerous clubs, and listed in Who's Who in America.

Author of:

Malden Health Series.

Principles of Health Education (translated into Chinese and Japanese).

Personal and Community Health (translated into Spanish).

Personal Hygiene.

Effective Living.

Health Safety Growth Series.

School Health and Health Education,

and many papers and articles on health education, child growth, and school health administration.

More recently, he has been Public Health Consultant with the Overseas Consultants who made the survey in Iran for the Persian government. At present he is consultant in Health Education to the World Health Organization and has just returned from Geneva, Switzerland, where he made a preliminary study of world-wide health education for that organization.

He is probably the only person alive who has taught both the father and the mother of a living King. These parents of the King of Siam were both students with Dr. Turner in the early twenties.

He is now assistant to the President of the National Foundation for Infantile Paralysis.

I take particular pleasure in making this presentation. A friendship of nearly thirty years and many professional contacts have given me a high regard for Dr. Turner; as a scientist, as a health expert and educator and as a friend. Born in little towns in Maine situated less than twenty miles apart, I can only say that if the State of Maine is a state of mind we both have the disease.

I know of no person, scientist or otherwise, who has so many loving friends in so many and so remote parts of the world.

Scientist, organizer, administrator, world-wide authority in health education, author, beloved teacher, and friend, I present for the William A. Howe Honor Award, Clair Elsmere Turner.

CHARLES H. KEENE, M.D.

* * * * *

TARGET, GYMNASIUM*

JENNIE SPADAFORA
National Safety Council

More than two-fifths of the school building accidents reported to the National Safety Council for the 1948-49 school year occurred in the gymnasium, swimming pool and showers while students were engaged in physical education activities.

The average gymnasium-basketball rate per 100,000 student-days was 0.36. However, the rates varied from 0.01 to 0.12 at the elementary school level and from 0.46 to 1.35 at the junior and senior high school level.

The average rate for other gymnasium activities was more than double the basketball rate—0.82. Moreover, the rate for other gymnasium accidents in each grade was higher than the basketball rate. Below the seventh grade the rates were less than the all-grades rate, but for grades seven through twelve they were well above it. The largest rate, 1.89, was recorded for the eleventh grade, followed by 1.84 for the eighth grade.

Swimming pool and showers had an average rate of 0.13. Seventh graders had the highest rate, 0.38, and tenth graders were next with a rate of 0.30.

The accompanying chart gives a comparison of the frequency of physical education accidents by month at the elementary, junior and senior high school level.

In general, gymnasium activities other than basketball were responsible for the greatest number of physical education injuries. Also, they were important in every month of the school year.

Basketball injuries in the elementary school were fairly important in February. In the junior and senior high school grades they were of considerable importance in each month from November through March, reaching a peak in January and February.

The rates for swimming pool and showers showed less monthly variation than the rates for basketball and other gymnasium accidents—particularly in the junior high grades. However, they were appreciably higher in December and February than in any other month of the school year.

Considering the relatively small amount of time allocated to gymnasium and swimming pool activities, the rates are high. Further, if rates could be based on hours spent at each location in the school building, the gymnasium and swimming pool would stand

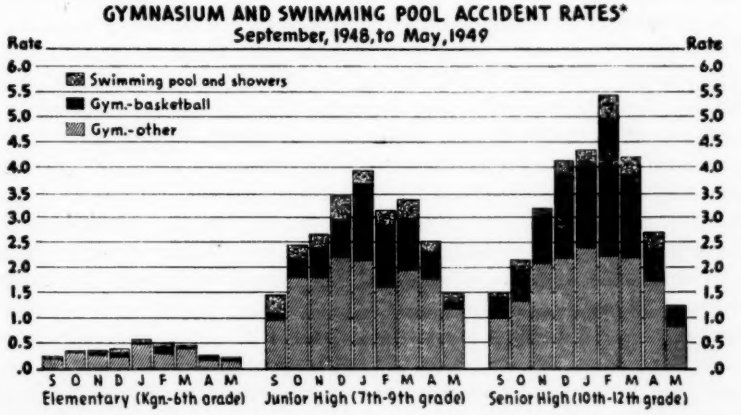
**Safety Education*, January, 1950, p. 8.

out even more prominently, compared to such places as classrooms. This warrants a careful analysis of physical education accidents, to determine the underlying factors involved and to serve as the basis of further prevention work.

GYMNASIUM AND SWIMMING POOL ACCIDENT RATE*
September, 1948, to May, 1949

	Sept.	Oct.	Nov.	Dec.	Jan.	Feb.	Mar.	Apr.	May
Elementary (Kgn.-6th Grade)									
Swimming pool & showers	.01	.00	.01	.06	.07	.05	.02	.02	.03
Gym—basketball	.00	.01	.05	.08	.02	.15	.04	.02	.02
Gym—other	.17	.32	.27	.23	.47	.29	.39	.21	.17
Junior High (7-9th Grade)									
Swimming pool & showers	.37	.31	.28	.44	.23	.34	.39	.22	.24
Gym—basketball	.07	.34	.56	.73	1.49	1.16	.99	.53	.13
Gym—other	.99	1.75	1.75	2.14	2.06	1.53	1.89	1.70	1.13
Senior High (10-12th Grade)					L	L	L	L	L
Swimming pool & showers	.15	.20	.17	.32	.21	.51	.34	.46	.11
Gym—basketball	.35	.59	.92	1.68	1.77	2.76	1.70	.55	.30
Gym—other	1.00	1.34	2.08	2.15	2.35	2.16	2.15	1.66	.83

Gymnasium activities, other than basketball, were responsible for the greatest number of physical education injuries in the school.



*Rate is the number of accidents per 100,000 student-days.

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EDITORIAL

The leading article of this issue on the "Ophthalmological Program in the Philadelphia Schools" deals with a school program in eye testing in the public schools that is rare if not unique in that it provides special eye examinations of pupils for those referred by the school physicians and recommendation of the cases needing special class assignment to the proper class or clinic and even the provision of glasses at public expense for the needy.

The questions and discussion following the paper of Dr. Lanciano were most interesting and instructive. These centered about the adequacy of the Snelling test card, which the Philadelphia school physicians use in the screening that is the basis of references to the clinics.

The concensus—and the very emphatically expressed opinion of Dr. Lanciano—was that the Snelling test was adequate if we keep in mind what is still the basic purpose of the school health examination—the screening out of pupils who deviate from normal and reference of these deviates to the family physician for diagnosis and treatment. The feeling is pronounced that the use of what the speaker, in discussion, called "gadgets"—and some of them very expensive—by the usual school physician was not called for, and that special eye examinations of special cases should be done only by specialists, using the numerous complicated tests of the ophthalmologist. The Philadelphia program offers this special service to parents at public expense. How far a community desires to go with this service is for the local public to decide. *C. H. K.*

ABSTRACTS AND NOTES

Study of Certification of School Nurses in U. S.,—A study of certification of school nurses by state departments of education which originated in the New Jersey State Department of Education, has been revised for the third time. The first study was made in 1931. Revisions followed in 1937, 1941, and 1949. The work was done by Lula P. Dilworth, Assistant in Health Education, Division of Health, Safety, and Physical Education. The current study was made in conjunction with the Education Committee of the School Nursing Section, National Organization for Public Health Nursing.

The specific purpose of these studies is to determine practices of state departments of education in issuing certificates for school nursing. Qualifications of all public health nurses are studied annually and reports made by the United States Public Health Service.

The current survey of certification of school nurses by state departments of education indicates steady progress toward the goal of securing better qualified nurses for work with the schools. In states having a public health nursing division in the state department of health, there was a marked tendency for the departments of health and education to work jointly on establishing standards for school nurse certification.

Legal authorization for school nursing was reported by a total of four or more states than replied in the affirmative in the 1941 study. States which made no legal provision for school nursing in 1941 but reported such a provision in 1949 are: Arizona, Delaware, Maryland, Massachusetts, Michigan, North Dakota, Tennessee, Washington, and Wisconsin.

Requirements for certificates by state departments of education range from a minimum of "registered nurse" to a maximum of a Bachelor's degree including or supplemented by the preparation in public health nursing approved by the National Organization for Public Health Nursing. During the war several states, because of the shortage of qualified candidates, issued temporary emergency certificates upon a statement of need by a superintendent of schools.

California requires, in addition to the public health nursing license, that the nurse who is to do school work must meet the requirements for a health and development certificate (six semester college hours of work in educational psychology, administration of a school health service and either social work, rural education or

child hygiene). A "temporary" certificate is issued on a superintendent's statement of "need."

Connecticut's requirements specify high school graduation, graduation from an accredited school of nursing, registration as a R.N. in Connecticut and 16 college semester hours of work in public health nursing and related fields in order to obtain a certificate for three years. With three years of successful experience in school nursing and another 16 hours of credit, a certificate good for 10 years may be obtained. This may be renewed at ten-year intervals if six additional credits are earned for the supervisor of school nursing, supervisory preparation, work in school and community nursing.

Idaho requires graduation from an accredited school of nursing and courses in Idaho school problems, law and history. The certificate is good for five years.

Illinois issues certifictes for one semester of college work in public health nursing, plus a year's experience as an assistant to a public health nurse or employed by a nursing organization giving approved supervision. It also will certify the nurse who has had no experience but has completed two semesters of college work and has successfully passed a state examination in public health nursing.

Indiana grants a one year "permit" to a nurse with six semester college hours in public health nursing subjects or with two years' experience under supervision as a public health or school nurse. This may be renewed annually if five additional semester hours are taken. A certificate is issued to a nurse with a Bachelor's degree which includes the approved preparation in public health nursing.

Louisiana does not certificate local school nurses but for the nurse employed by the state education department, a Bachelor's degree, preparation in public health nursing, five years of experience in public health nursing and special preparation for working in school health programs is required.

Maine issues a permanent certificate to the nurse who is a high school graduate, has the approved preparation in public health nursing, and has had one year of experience in public health nursing.

Montana issues a certificate good for three years to a nurse who is a high school graduate and who has either six semester college hours of preparation in public health nursing or one year's experience in public health nursing. This is renewable for five year periods if additional six hours of work is taken.

New Jersey issues a certificate for three years to a nurse who is a high school graduate, who has graduated from an accredited school of nursing and who has completed six semester hours of approved courses. A permanent certificate is issued for an additional 12 semester hours of college work, and three years of approved work in school nursing. The nurse employed by the State Education Department must have a Master's degree, including preparation in public health nursing, education, and health education.

New York issues a certificate good for ten years to a high school graduate who has completed the curriculum in an approved school of nursing, and 30 semester hours of approved college courses in public health nursing and education. A permanent certificate is issued when an additional 30 hours are obtained. During the years of shortage of qualified candidates due to the war, a "temporary" emergency certificate was issued on the superintendent's statement of need. The nurses employed by the State Education Department must have a Bachelor's degree, including or supplemented by the approved preparation for a permanent certificate, and seven years of nursing experience, including three years of nursing supervision, one year of which was supervision of school nurses.

Oklahoma certificates are issued by the *State Health Department* and require only a nurse's registration in the state.

Oregon is working on the problem of establishing standards for certification.

Pennsylvania issues a certificate to a nurse who is a high school graduate, who has completed courses in the history of the United States and of Pennsylvania. A permanent certificate requires, in addition, 12 semester hours in public health nursing. The nurse employed by the State Education Department must hold a permanent college certificate and have a Master's degree with work in supervision and health education.

Rhode Island will certificate annually a nurse who earns four credits each year. A five year renewal certificate is issued to a nurse with 30 semester hours in public health nursing.

Vermont gives a certificate requiring the nurse to complete six college hours within the year.

Wisconsin, since 1941, has passed a law which permits the employment of school nurses. Nurses may be employed by the local board of education or the local board of health. Certification of school nurses is required and this is a function of the licensing

division of the Department of Public Instruction. Standards were established in 1949 by a committee of three representing the state departments of public instruction and health, and the board of nurse examiners.

Provisions are made for issuing both the limited and the permanent certificate. To receive the former a nurse must be a high school graduate or its equivalent and eligible for university matriculation, a graduate of an approved school of nursing and eligible for state registration, employed in Wisconsin, and have not less than 15 semester hours of credit in an approved course in public health nursing. The permanent certificate is based on the above qualifications plus the completion of not less than one academic year in an approved course in public health nursing. The permanent certificate is based on the above qualifications plus the completion of not less than one academic year in an approved course in public health nursing within three years after employment.

The State Department of Public Instruction may issue teachers permits or licenses to qualified nurses.

Advisory, supervisory, or consultant school nursing service is provided by the State Department of Health.

Wyoming's certificate is issued for three years on nurse registration only. This may be renewed for three years if seven semester hours of college work are obtained. With six years of experience and 19 semester hours of college work, a life certificate may be obtained. Briefed from mimeograph report for the Journal of School Health by G. E. C.

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Track Work and a Boy's Heart.—To the Editor: I have always thought that track and crew were too strenuous on a boy's heart and now my boy aged 12 is anxious to do track work. Am I right or wrong? He ran 1 mile in seven and one-half minutes recently. —*George A. Bakke, M.D., Oakland, Calif.*

ANSWER—An official statement of the Committee on the Role of Exercise in Physical Fitness states that "a normal healthy child cannot do himself permanent organic injury by physical exertion." However, the advisability of specialization in distance events by a boy aged 12 is open to question. Track events for youth of the prepubescent age group may well be confined to those of short duration, such as the 40, 50 and 60 yard dashes. It has also been widely recommended that competition for youths of this maturity level be limited to a few invitational and

informal play-day events, in which participants are carefully classified on the basis of one of the formulas available for the purpose: e.g., age-height-weight determinations. Ordinarily, fatigue and its associated distress act as a "safety valve" in preventing overstrain, and cause a child to slow down or stop activity before the physiologic limit or ultimate capacity of the organs involved is reached. However, the emotional stimulus which is often associated with a highly competitive situation may result in carrying the activity past healthful fatigue to a stage of harmful exhaustion. When track events for the younger age groups are confined to those demanding limited periods of sustained effort rather than long trials of endurance this possibility is reduced if not eliminated. Determination of physiologic soundness by medical examination should, of course, be a requisite to participation in strenuous activity, and it should be kept in mind that some children react unfavorablly to exercise and vary in their ability to benefit from it. Journal of the American Medical Association, November 19, 1949, p. 884.

* * * * *

Jungle Gyms,—To the Editor: Our school system is about to install some jungle gyms for the children in the school yards. The question has been brought to me, whether it is safer to have beach sand which will not pack for the base or a firm base such as concrete or asphalt. I believe that there will be fewer sprains and fractures from falling if the base is firm and not uneven and shifty, as it would be with sand.—*William F. Mahoney, M.D., Saco, Maine.*

ANSWER—The answer to this question depends somewhat on the kind of maintenance available. A properly kept up pit beneath apparatus from which there is possibility of falling offers some protection for children. Unless the pits can be kept filled and properly leveled, they may be more of a hazard than a safeguard. Recommendations on care of apparatus and facilities include the following item under care of gymnasium frames, bars and rings: "Pits beneath apparatus should be filled with sand and/or shavings, which should be kept loose and comparatively level." The construction of the jungle gym and castle tower makes the possibility of falls to the ground from this type of apparatus less likely than from rings or horizontal bars. In many situations, a smoot asphalt surface under the jungle gym or castle tower will prove the best practical solution. Where there is adequate custodial service to insure continual top-grade upkeep, sand pits will have considerable protective value. Journal A.M.A. Nov. 19, 1949, p. 884.

Salivary Lactobacilli and Dental Caries,—Much of the current theory as to the cause and control of dental caries is based on the assumption that the salivary Lactobacillus count is a dependable index to the tendency of persons to have tooth decay within the near future. Statistical confirmation of this assumption was sought by Boyd[1] and his associates of the Department of Pediatrics, University of Iowa. The Lactobacillus counts of 64 teen aged girls were compared with the progress of individual tooth decay over a period of thirty months. Eleven of these girls did not reveal advance of caries during this period. In these 11 the Lactobacillus counts varied from 30,000 to 360,000, an average of 92,500 per cubic centimeter of saliva. A second group, 15 girls, had an average of 9 to 10 decayed, missing or filled teeth during the same period. In this group the Lactobacillus counts varied from 35,000 to 720,000, an average of 112,000 per cubic centimeter. A third group of girls had an average of only five new lesions during the observation period. In this group the salivary counts varied from 30,000 to 720,000, an average of 104,500 lactobacilli per cubic centimeter. The average Lactobacillus count tended to parallel the rate of progress of caries when whole groups were compared. A great inconsistency, however, is seen in comparing the count and rate of caries progression for individual subjects. Equally low and equally high counts were recorded for individual subjects regardless of their subsequent caries histories. In this experiment an excessive number of salivary lactobacilli apparently was not the essential causative factor in tooth decay. Journal A.M.A., December 10, 1949, p. 1059.

* * * * *

Tuberculosis,—200 Schools Win Class "A" Awards. In 14 counties, health conscious students really rolled up their sleeves in a big way. Their reward for the work they did were tuberculosis control awards from the American School Health Association.

During the school year 1948-49, 200 schools received Class "A" certificates, and 45 were awarded Class "B" certificates, representing 14 counties.

Class "C" and "D" certificates are also awarded, and up to April 1, 1949, 827 schools had been certified since the inauguration of the plan.

Minnesota qualifications for a Class "A" award include the testing at least every other year of 95-100 per cent of the children.

[1]Boyd, J. D.; Cheyne, V. D., and Wessels, K. E.; Proc. Soc. Exper. Biol. and Med. 71:535 (August) 1949.

Christmas Seal funds are financing tuberculin testing surveys throughout the state.

A new edition of the tuberculin testing manual for professional workers is available through the Minnesota Public Health Association, 614 Portland Avenue, St. Paul 2.

School Health News, Minnesota Departments of Health and Education, January, 1950.

* * * * *

School Nurses,—"The Joint Committee on the Nurse in the School Health Program suggests when workshop groups on school health are organized, that consideration be given to inviting nurses to participate in the planning; that nurses be encouraged to attend; and that more materials of interest to school nurses be included."

* * * * *

Cooperating Committee,—"At the October meeting of the American Public Health Association, the School Health Section Council voted to recommend that a committee be set up among the health education divisions of the American Association for Health, Physical Education, and Recreation, the American School Health Association, and the School Health Section of the American Public Health Association for the purpose of determining more effective means of cooperation on projects of mutual interest."

* * * * *

Accidents in Industry,—Workers in American industry were safer in 1948 than in any year in history, the National Safety Council reported today.

Reports to the Council, as shown in the 1949 edition of its statistical yearbook, "Accident Facts," indicates that disabling injuries per 1,000,000 man-hours averaged 11.49 for all reporting industries in 1948. This is a 13 per cent reduction from the 13.26 rate the year before, and a new record. An average of 1.12 days were lost per 1,000 man-hours worked in all industries last year, a reduction of 9 per cent from 1947 — also the best on record.

In both years lumbering had the highest accident frequency rate, but it was reduced 18 per cent in 1948 — from 59.74 to 49.04. Coal mining, with the greatest accident severity rate both years, went down from 7.96 to 7.61, a 4 per cent reduction.

Communications again ranked as the safest among reporting industries in 1948. It had the lowest frequency and severity rates last year, as well as the year before.

New California Organizations,—The California Division of the American School Health Association reports that a Northern California section of the California Division is being organized. The first annual conference will be held in Northern California April 1, at Sacramento.

Two months ago, a Northern California Division of the California School Health Nurses Association was organized and "is going along splendidly." From letter of Richard G. Soutar, M.D., President, California Division, American School Health Association.

* * * * *

State of New York,—The New York State School Physicians Association held a joint meeting with the New York State School Nurse-Teachers Association on January 26th and 27th at Syracuse. At the Luncheon Session two hundred seventy-five were present, and fifty were turned away for lack of dining room space. The School Nurse-Teacher Association has more than 900 members.

* * * * *

Caveat Emptor,—In a laudable though sometimes overenthusiastic endeavor to synthesize and market new and better drugs for old and distressing illnesses the fact is sometimes lost sight of that, though effective, some of these drugs eventually prove harmful.

It seems definitely proved, for example, that folic acid will bring about a remission in pernicious anemia, but there is ample evidence that in some cases paralysis has followed the administration of the drug, and, to the patient, it is quite unimportant whether the paralysis is caused directly by the drug or whether the tendency to neurologic involvement is simply enhanced. Benadryl, used to combat anaphylactic phenomena, may itself cause urticaria. Penicillin (an antibiotic followed by very few untoward effects) may cause severe stomatitis when used in lozenges. The administration of aminopyrine—once thought to be a harmless analgesic—has been followed by death from agranulocytosis in many cases, its toxicity not having been demonstrated until nearly fifteen years after its introduction. The nitrogen mustards have unquestionably caused thrombocytopenia, leukopenia and anemia. The hemolytic staphylococcus has become penicillin-fast.

And now, in this issue of the *Journal,* comes a warning from one author that the very valuable drug quinidine may bring on thrombocytopenia of considerable severity and from others that Presidon, once considered harmless, may cause fatal agranulocytosis. The manufacturers immediately withdrew the product from

the market, but it may still be on the dispensing doctors' shelves or in their bags.

The lesson that should be but seemingly has not been learned is that any new drug, however efficacious it may appear, must be regarded as potentially dangerous until the contrary has been proved, and that this may take years; for more often than not the untoward symptoms are due to an individual idiosyncrasy of the patient to the drug rather than to a toxicity of the drug to all persons. From *The New England Journal of Medicine*, Jan. 12, 1950, p. 69.

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Committee Recommendation at Annual Meeting,—That active committees submit a written report of their action to date. Although the work of the committees may not be completed, the annual report should be presented.

These reports should be publicized as thoroughly and as often as possible in the Journal of the Association.

That the President's annual report, with such recommendations as he chooses to make, be publicized at an early date following the annual meeting. Signed,

H. F. Kilander,
C. Outland,
P. F. Kinney.

Resolution,—The benefits of American Medcine should be made available to the people of the United States principally through voluntary health insurance in order that the people of all economic status can best be served and that no groups be neglected.

Until such system is given a thorough trial, the Council of the American School Health Association goes on record against any form of compulsory health insurance.

It is recommended that a copy of this resolution be forwarded to the President of the United States and to the Chairman of the respective committees of the House and the Senate, urging them to promote expansion of voluntary health insurance.

* * * * *

Workshops,—It is requested that colleges and universities planning to offer "workshops" in health education the summer of 1950, send to the Journal Editor as soon as possible information

as to institution, place, dates and leaders the "deadline" for material to be used — in the May issue — is April 15, 1950.

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REVIEWS

"Invited and Conquered,"—Historical Sketch of Tuberculosis in Minnesota, *J. Arthur Myers, Ph.D., M.D.,* published by the Minnesota Public Health Association, St. Paul, Minn., 1949.

Among the impedimenta that white settlers brought to Minnesota was tuberculosis. The disease was rampant in the countries, colonies and states from which these white immigrants came.

The author traces the beginnings of the early migration into Minnesota and the mingling of these people, often diseased, with the Indians of that era. After discussing the nature and cause of tuberculosis, its diagnosis and treatment, the tuberculosis problem and the methods proposed before 1900 for controlling the disease in Part I, the author devotes some 629 of the 738 pages to tuberculosis in Minnesota in the twentieth century. This is a detailed factual account of the steps taken in organizing and carrying on the battle against the scourge, and a presentation of the persons who have carried on the anti-tuberculosis activities.

In conclusion, under the title "Mileposts," there is presented a detailed chronological outline of the steps taken to try to overcome this disease in the state. That these steps have been so largely successful is a fact due to the energy, earnest efforts, and great skill of the author of the story — J. Arthur Myers, ably assisted by Edward A. Myerding, M.D., for the last twenty-five years Executive Secretary, Minnesota Public Health Association.

Dr. Myers is Professor of Medicine and Preventive Medicine and Public Health, University of Minnesota Medical and Graduate Schools. Since its organization in 1934, he has been chairman of the committee on Childhood Tuberculosis of the American School Health Association.—*C. H. K.*

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MEETINGS

American School Health Association and the American Public Health Association at St. Louis, Missouri, October 29 - November 3, 1950.

American Association for Health, Physical Education and Recreation at Dallas, Texas, April 17-21, 1950.

New York State Sanitary Conference and **New York State School Physicians Association** at Lake Placid, N. Y., June 5-8, 1950.